TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Westrock MWV LLC

MFDR Tracking Number
M4-16-0685-01

Carrier's Austin Representative
Box Number 55

MFDR Date Received
November 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to rule 137.100 (g) and insurance carrier shall not deny treatment solely because the diagnosis or treatment is not specifically addressed by the Division treatment guidelines or Division treatment protocols."

Amount in Dispute: $489.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on December 7, 2015. 28 Texas Administrative Code 133.307 (d)(1) states, "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." As no response was received, this dispute will be based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 29, 2014	Pharmacy Services	$489.96	$489.96

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out requirements of medical claim submission for workers compensation claims.
3. 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmacy services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - D20 – Previously denied by adjuster with PBM
    - P12 – Workers' compensation jurisdictional fee schedule adjustment
    - 29 – The time limit for filing has expired

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied the disputed services as 29 – The time limit for filing has expired. 28 Texas Administrative Code 133.20(b) states in pertinent part, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Review of the submitted documentation finds an explanation of benefits for the pharmacy services in dispute for date of service November 29, 2014 that is dated December 11, 2014. Therefore, the Division finds this denial code is not supported. The carrier denied the services as D20 – "Previously denied by adjuster with PBM." Insufficient evidence was found to support a denial by an adjuster. Therefore, this denial will not be considered. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. The dates of service in dispute are related to pharmacy services. 28 Texas Administrative Code §134.503(c) states,

    The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

    (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

    (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

    (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

    (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection;

Date of Service	Name of medication	Reported Units	Amount billed	MAR (AWP per unit) x (number of units) x 1.25 + $4.00
November 29, 2014	Baclofen Powder (Jar)	5.4	$184.68	$35.63000 x 5 x 1.25 + $4.00 = $226.69
November 29, 2014	Amantadine HCL Bulk Powder (Bottle)	3	$38.46	$24.22500 x 3 x 1.25 + $4.00 = $94.84
November 29, 2014	Gabapentin Powder (Bottle)	4	$188.10	$59.85000 x 4 x 1.25 + $4.00 = $303.25
November 29, 2014	Amitriptyline Bulk Powder (Bottle)	2	$30.70	$18.24000 x 2 x 1.25 + $4.00 = $49.60
November 29, 2014	Bupivicaine HCL	1	$48.02	$45.60000 x 1 x 1.25 + $4.00 = $61.00
		Total	$489.96	$735.38

3. The total allowed amount for the services in dispute is $735.38. This amount is calculated based on NDC number found in box 21 of DWC066 and the number of units found in box 23 of DWC066 of "60". The requestor is seeking $489.96. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $489.96.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $489.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		March , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.